Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative

Box Number 45

MFDR Date Received

MARCH 14, 2013

MFDR Tracking Number

M4-13-1792-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the carrier has failed to adjudicate our 03-19-2012 electrodiagnostic claim correctly."

Amount in Dispute: $2,780.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Kirt Repp and will maintain its denial for ANSI code 197-Payment denied/reduced for absence of precertification/preauthorization…The requestor billed utilizing ICD 9 code 847.2 which directed the Office to review the Low Back chapter of the ODG (Exhibit A) which does not show a recommendation for Nerve Conduction Studies, it does however state that needle EMG's are recommended in some cases. With these findings, the Office maintains the procedures in dispute needed to be reviewed by our utilization review physician to substantiate the medical necessity."

Response Submitted By: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	CPT Code 95903 (X4)	$295.00/each	$0.00
	CPT Code 95904 (X6)	$225.00/each	$0.00
	CPT Code 95934-50	$250.00	$99.61
TOTAL		$2,780.00	$99.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
3. 28 Texas Administrative Code §133.250, effective May 2, 2006, sets out the timeframe for filing a request for reconsideration of payment.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers compensation state fee schedule adjustment.
- 197-Payment denied/reduced for absence of precertification/preauthorization.
- 97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjucated [sic].
- 17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
- Please resubmit with the NCD/F-Wave reports for further review. F-waves not recommended per ODG for DX. Per rule 134.600(p)(12) carrier is not liable for treatment and/or services provided in excess of the Divisions treatment guidelines unless in emergency or pre-authorization rules.
- 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 29-The time limit for filing has expired.
- A request for reconsideration must be submitted no later than 10 months from the date of service per rule 133.250(b).

Issues

1. Does a timely filing issue exist?
2. Does a preauthorization issue exist?
3. Does an unbundling issue exist?
4. Is the requestor entitled to reimbursement for CPT code 95934?

Findings

1. According to the reconsideration explanation of benefits, the respondent raised the issue of timely filing.

   28 Texas Administrative Code §133.250(b) states "The health care provider shall submit the request for reconsideration no later than eleven months from the date of service."

   A review of the reconsideration explanation of benefits indicates the bill was received on February 20, 2013, this date is within the timeframe allowed by 28 Texas Administrative Code §133.250(b); therefore, a timely filing issue does not exist in this dispute.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95903 based upon reason code "197."

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The requestor billed CPT code 95903 for the diagnoses 847.2-lumbar sprain and strain.

   According to the Low Back Chapter of the Official Disability Guidelines (ODG), nerve conduction studies are not a recommended treatment for a lumbar sprain and strain; therefore, the disputed nerve conduction studies, CPT code 95903, required preauthorization. As a result, a preauthorization issue exists and reimbursement is not recommended.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95904 based upon reason codes "97."

   On the disputed date of service, the requestor billed CPT codes 99212, 95860, 95934-50, 95903 and 95904.

   Per CCI edits, effective January 1, 2012 CPT codes 95903 and 95904 are components of code 95860. As a result, reimbursement cannot be recommended.

4. CPT code 95934-50 is defined as “H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle.”

   The respondent indicated on the explanation of benefits that payment was disallowed based upon reason code “W1.” The documentation does not support this denial.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 54.86.

   The Medicare Conversion Factor is 34.0376

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77076, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

   Using the above formula, the Division finds the MAR is $99.61. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $99.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $99.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/26/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.